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	17E630	A. BUILDING _____ B. WING _____	C 10/23/2012

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ANTHONY COMMUNITY CARE CENTER	212 N 5TH AVE ANTHONY, KS 67003

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F 000	INITIAL COMMENTS The following citations represent the findings of the complaint survey for complaints #59570 and #60752.	F 000		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility census totaled 31 residents with 6 included in the sample. The sample included the review of the medication regimen for 3 residents.	F 329		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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Based on observation, interview, and record review, the facility failed to provide adequate monitoring of medications for 2 of 3 residents. (#4 and #5). Both residents were on medications with narrow therapeutic ranges. The facility failed to conduct a laboratory blood test as ordered for resident #5, failed to identify, assess and monitor side effects of bruising for resident #5. The resident's blood became too thin and the resident required hospitalization. The facility failed to consult with the physician regarding a low laboratory result for an anti-seizure medication for resident #4. The staff failed to administer the anti-seizure medication as ordered, and the resident experienced a seizure and a hospitalization.

Findings included:

- Review of an Admission MDS (Minimum Data Set 3.0-a required assessment) dated 8/30/12 identified resident #5 with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), rejected care 4-6 days of the 7 day assessment, required extensive assistance from 2 staff with bed mobility, transfers, dependent on staff for locomotion on/off the unit, and dependent on two staff for toilet use. It also identified the resident took an anticoagulant medication 2 days of the 7 day assessment period.

Review of the care plan, dated 8/31/12, identified resident took psychotropic medications and provided guidance to staff on what side effects/adverse effects to monitor the resident for. The care plan directed staff to administer medications as ordered. The care plan failed to

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identify the resident received an anticoagulant medication and failed to provide guidance to staff what side effects or adverse effects to monitor for.

Review of the resident's orders, signed by Consultant A on 8/21/12, revealed Consultant A ordered staff to administer the anticoagulant medication Warfarin 4mg (milligrams) daily on Monday and Thursdays, and to administer 2mg daily on the other days. Consultant A also gave the order for staff to obtain a PT/INR (a laboratory blood test to monitor how thin the resident's blood had become) in one week, or 8/28/12. Review of the record revealed that the staff failed to obtain the laboratory test as ordered to monitor the effectiveness of the Warfarin.

Review of the nurse's notes revealed the following:
On 8/25/12 at 8:00 a.m., staff documented the resident's fourth toe on the right foot was bruised. The resident told the staff he/she had hit it on something, but did not realize that it was bruised. The staff faxed the physician and placed a call to the family. The record lacked any measurement of the bruise or any further monitoring of the area.

On 9/3/12 at 9:00 p.m., staff documented the resident had multiple bruises to the body. The resident stated the bruises were from bumping into things. Staff documented the resident received Warfarin and a side effect was bruising, and there was a black box warning and staff were monitoring by conducting routine laboratory tests and continued resident assessments. Review of the record revealed staff had not conducted any laboratory tests and the record lacked any

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F 329	Continued From page 3 assessments or monitoring of the "multiple bruises." On 9/17/12 at 2:58 p.m., staff identified the resident complained of not feeling well at 2:30 p.m. The staff assessed the resident as pale, and with respirations of 36 per minute. The staff sent the resident to the local emergency room. At 7:00 p.m., the resident returned to the facility. The resident told the staff the doctor had stated the resident was anemic (had a low blood count), and ordered staff to obtain a CBC (a laboratory test to check for anemia) in one week. The physician also ordered staff to administer iron to the resident and to administer oxygen to keep the oxygen saturation levels (how much oxygen in the blood) above 90%. On 9/18/12 at 3:00 p.m., staff documented the resident's skin as pale, and at times the resident had a small drop of blood that came from the resident's nose. At 7:30 p.m. that night, the staff sent the resident to the emergency room because the resident had a bright red nose bleed. Staff assessed the resident as pale and with cool skin that appeared more pale that the previous night. The resident returned to the facility at 10:00 p.m. with orders to see Consultant A in the morning. The emergency room attempted four times to conduct a laboratory test to monitor how thin the resident's blood was, but was unable to conduct the test. On 9/19/12 at 12:00 noon, staff documented the resident was out to see Consultant A and the resident continued to be extremely bruised. The record lacked an assessment of the bruising or ongoing monitoring of the bruises.	F 329		

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Review of the nurse's notes revealed the resident continued to have bleeding from the nose, increased bruising to the arms, torso, legs and feet which got larger, as well as visits from Consultant A until 9/21 at 12:10 p.m., when the resident became incoherent and the facility sent the resident into the emergency room. The resident's Protime (monitors the effectiveness of the Warfarin) was >200 seconds (normal is 9-11.5 seconds) and the INR (International Normalized Ratio--works in conjunction with Protime to monitor blood clotting time) was >18. The resident's DPOA (Durable Power of Attorney) called the facility on 9/23/12 at 1:00 p.m. and told the staff the resident had 3 units of blood and the resident's PT/INR was more stabilized.

On 10/19/12 at 1:30 p.m. Administrative staff C and Administrative Nurse G stated that the staff missed getting the order for the PT/INR on 8/28/12 as ordered because the resident's admission did not follow the normal manner in which resident admissions occurred. Staff G stated he/she had provided training to staff on how to assessment, investigate and monitor bruising on residents. Staff G provided a sheet addressed to the licensed nursing staff that gave examples of the facility's policy on assessment, investigation and documentation of skin issues, including bruising. Staff C and G confirmed the facility staff failed to follow the policy to monitor bruising on this resident. When asked if the staff had contacted the Consultant Pharmacist to review the resident's medication regimen to determine if it contained any irregularities, staff C stated that he/she had not thought to contact the Consultant Pharmacist.

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F 329	Continued From page 5 On 10/22/12 at 1:15 p.m., Consultant A stated he/she did not feel like the staff had failed to notify the medical staff in a timely manner of the resident's bruising. Consultant A stated the resident went from being independent to requiring extensive assistance, and Consultant A said that could cause the bruising, as well as other disease processes, including those that caused the resident to swell, or become edematous, some psychiatric issues, and then just generally the age of the resident's skin. The facility failed to monitor the use of an anticoagulant medication for a resident by obtaining ordered laboratory testing in a timely manner and failing to assess and monitor for side effects, including bruising. The resident required a hospitalization and 3 units of blood. - Review of the recapitulation of orders, signed on 9/18/12, identified resident #4 with a diagnosis of convulsions. It also identified an order for staff to obtain a Dilantin level (a blood test that monitors how much anti-seizure medication--Dilantin--is in the blood) every 6 months. The facility had assigned the months of June and December for staff to obtain the ordered laboratory test. Review of the annual MDS (Minimum Data Set 3.0-a required assessment) dated 10/3/12 identified the resident with severely impaired cognition, dependent on two staff for bed mobility, transfers, and bathing. Review of the care plan, last dated on 10/9/12 revealed the resident had a history of unspecified	F 329		

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convulsions, and that put the resident at risk for adverse reactions/effects from Dilantin (anti-seizure medication) used to treat the resident's convulsions. The care plan directed staff to obtain the necessary laboratory testing as ordered by the physician to monitor the Dilantin level in the resident's blood.

Review of the resident's record revealed staff obtained a Dilantin level on 12/7/11. The result was 4.1 micrograms per milliliter, or ug/mL. Normal therapeutic range is 10-20 ug/mL. According to the faxed laboratory result, the staff faxed the result of the Dilantin level to Consultant B. The staff never called Consultant B to ensure that he/she received the abnormal results of the laboratory test.

Review of February 2012 MAR (Medication Administration Record) revealed that the physician had ordered staff to administer Dilantin 300mg (milligrams) by mouth three times a day since March 2010. Staff assigned the times of AM, Lunch, and PM for the administration times of the Dilantin. According to the MAR, staff administered the medication as ordered except for 2/15 and 2/16. On those two days, staff failed to sign they administered the AM dose of the Dilantin.

Review of a nurse's note, dated 2/17/12, identified staff were assisting the resident with a shower between 6:30 and 7:00 a.m. when the resident had a seizure. Staff called the licensed staff on duty, Administrative staff C, who stayed with the resident and directed the direct care staff to go call EMS. The resident then went to the emergency room. While in the emergency room,

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the hospital personnel obtained another Dilantin level and determined that it was low at 4.6 ug/mL. The hospital staff stopped the seizures, changed the resident's Dilantin level, and sent the resident back to the facility with an order to obtain a Dilantin level in 2 weeks. The staff obtained the Dilantin level on 2/29/12 and the resident's Dilantin level at that time was within therapeutic range, 14.3 ug/mL. The record revealed the staff had not obtained another Dilantin level since that time, over 7 months.

Observation on 10/18/12 at 4:15 p.m. revealed direct care staff D and direct care staff E used a mechanical lift and sling to assist the resident from the bed into a wheelchair. The staff changed the resident ' s incontinent brief that was wet, provided perineal care, then replaced the brief. Both staff then transferred the resident with a mechanical lift from the bed into a Geri-chair (a reclining chair), then assisted the resident out of the room to the dining room.

Observation on 10/19/12 at 8:10 a.m., revealed direct care staff E and F assisted the resident from the wheelchair into bed with the use of a mechanical lift. Both staff used good technique and made sure they situated the resident in the middle of the bed. Both staff stated they had heard the resident had seizures, but neither staff had witnessed the resident having a seizure.

On 10/19/12 at 1:18 p.m., Administrative staff C stated he/she remembered resident #4 having a seizure as that was staff C's first day at work. Staff C and Administrative Nurse G both stated they did not think the staff had called Consultant B to make sure he/she received the faxed results

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F 329	Continued From page 8 of the resident's laboratory results. Both staff C and G were unaware that the staff had failed to administer the morning dose of the anti-seizure medication to the resident 2 days before the resident's seizure. On 10/22/12 at 2:30 p.m., Consultant B stated he/she could not remember if the staff had notified him/her about the resident's low Dilantin blood level in December 2011, but that he/she normally tried to keep the resident's blood level in the therapeutic range of 10-20 ug/mL. He/she also said he/she relied upon the facility to obtain the ordered laboratory testing and then report the results to him/her. The facility failed to provide adequate monitoring of the anti-seizure medication Dilantin through a failure to consult with Consultant B regarding a low Dilantin blood level. The facility also failed to follow the order and administer the Dilantin as ordered. The resident experienced a seizure and required a trip to the emergency room for further treatment.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		

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This REQUIREMENT is not met as evidenced by:
The facility census totaled 31 residents with 6 included in the sample. The sample included the review of the medication regimen for 3 residents. Based on interview, and record review, the pharmacist failed to report irregularities in the drug regimen and failed to review the drug regimen monthly for 2 of 3 sampled residents. (#4 and #5)

Findings included:

- Review of physician's orders for resident #5, signed by Consultant A on 8/21/12, revealed Consultant A ordered staff to administer the anticoagulant medication Warfarin 4mg (milligrams) daily on Monday and Thursdays, and to administer 2mg daily on the other days. Consultant A also gave the order for staff to obtain a PT/INR (a laboratory blood test to monitor how effective the Warfarin was or how thin the resident's blood had become) in one week, or 8/28/12. Review of the record revealed that the staff failed to obtain the laboratory test as ordered to monitor the effectiveness of the Warfarin.

Review of an Admission MDS (Minimum Data Set 3.0-a required assessment) dated 8/30/12 identified the resident with a BIMS (Brief Interview for Mental Status) score of 15/15 (indicated little to no cognitive impairment), and received an anticoagulant medication for 2 days of the 7 day assessment period.

Review of the resident's care plan, dated 8/31/12,

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revealed it lacked identification of the medications black box warning or guidance to staff to monitor for side effects/adverse effects of the Warfarin, including bleeding.

Review of the medical record revealed the staff documented the resident started to exhibit bruising of unknown etiology on 8/25/12. The documentation showed the resident continued to have more bruising on the arms, legs, feet and torso, and started to have severe nose bleeds. On 9/21/12, 30 days after admission to the facility, the resident required a hospitalization for blood because the resident's Warfarin level had gotten too high.

Review of Consultant H's monthly drug regimen reviews revealed the monthly visit for August occurred on 8/17/12, or before the resident admitted to the facility. The September visit occurred on 9/30/12, or after the resident admitted to the hospital. The resident had been in the facility for 30 days, and during that time, Consultant H failed to conduct a drug regimen review to determine if drug irregularities existed.

On 10/19/12 at 1:30 p.m., Administrative staff C stated he/she never thought to consult with Consultant H about the resident's drug regimen.

On 10/22/12 at 11:40 a.m., a call was placed to Consultant H. Consultant H was unavailable, so a message left to return the call. Consultant H did not return the call by 10/23/12 at 11:30 a.m.

The facility failed to ensure Consultant H reviewed a new resident's drug regimen within 30 days.

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F 428	Continued From page 11 - Review of the recapitulation of orders, signed on 9/18/12, identified resident #4 with a diagnosis of convulsions. It also identified an order for staff to obtain a Dilantin level (a blood test that monitors how much anti-seizure medication--Dilantin--is in the blood) every 6 months. The facility had assigned the months of June and December for staff to obtain the ordered laboratory test. Review of the record for resident #4 revealed that on 12/7/11, the facility obtained a Dilantin level. The level revealed it was low, at 4 ug/mL (milligrams per milliliters). Normal therapeutic range was 10-20 ug/mL. The staff faxed Consultant B the result, but did not follow up with a call when Consultant B did not respond to the low result. Review of the pharmacist ' s monthly drug regimen reviews revealed that in 12/11 Consultant H reviewed the resident's drug regimen and identified the resident's low Dilantin level. Consultant H did not follow up on the irregularity with the DON (Director of Nurses) or the attending physician in the reviews conducted 12/11, 1/12 or 2/12. Review of the resident's medical record revealed that on 2/29/12 the facility obtained a Dilantin level and the level was within therapeutic level at 14.3 ug/mL. Review of the pharmacist's monthly drug regimen reviews revealed that the monthly drug regimen review on 3/12, Consultant H identified the facility obtained the Dilantin level every 6 months. For	F 428		

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each monthly review completed through 9/12, Consultant H did not identify any irregularities in the resident's drug regimen review.

Review on 10/19/12 of the medical record revealed that since 2/29/12, the facility had failed to obtain another Dilantin level to monitor the use of the medication. The facility failed to follow the physician's order to obtain a Dilantin level every 6 months. Consultant H failed to identify the irregularity in the monthly reviews of 8/12 and 9/12 and notify the DON and the attending physician.

On 10/19/12 at 1:30 p.m., Administrative staff C stated that he/she felt disappointed that Consultant H did not identify the irregularity.

On 10/22/12 at 11:40 a.m., a call was placed to Consultant H. Consultant H was unavailable, so a message left to return the call. Consultant H did not return the call by 10/23/12 at 11:30 a.m.

The facility failed to ensure Consultant H reported the low result of a Dilantin level and the need for another Dilantin level as ordered for a resident with seizures.